THERAPIST APPROACH-AVOIDANCE RESPONSES TO CLIENT EXPRESSIONS OF HOSTILITY AND DEPENDENCY AS A FUNCTION OF CLIENT SEX, THERAPIST SEX, AND COMPATIBILITY

By

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To all my therapist-friends and

friend-therapists who helped me along.

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This therapy analogue study matched each of ten professional therapists, five males and five females, with four experimental subjects from university undergraduate classes, selected to form high- and low-compatibility dyads with all sex combinations represented. Single therapy interviews were video-taped and then edited into three three-minute segments representing the beginning, middle, and end phases of the interview. Using typed transcripts from the interview segments, raters identified clients' expressions of hostility and dependency and labelled the subsequent therapist responses as approach or avoidance. Four dependent variables of rates of approach and avoidance to hostility and dependency were computed. It was hypothesized that, if sex-role stereotypes were influencing the therapy process, it would be most apparent in the therapists' responses to clients' expressions of hostility and dependency since these behaviors are central in sex-role stereotypes and discriminate "masculine" and "feminine" sex-roles. Specifically, stereotyping would be operating in therapy if therapists varied their responses to these behaviors as a function of sex of the client.

The data were analyzed with a split-plot repeated measures design, using analysis of variance procedure (2 x 2 x 2 x 4) with client sex, therapist sex, compatibility, and four rate scores. Client sex failed to emerge as a significant variable influencing rate of approach and avoidance to clients' expressions of hostility and dependency. There was a significant interaction effect of therapist sex by compatibility by rate. Tests for simple effects indicated that male therapists' responses to hostility were influenced by compatibility with clients. Female therapists were not influenced by compatibility with clients and in general responded to clients at a more consistent intermediate rate than male therapists. Other analyses were conducted through Pearson correlations between specific compatibility scores and rates separately for each sex of therapist and client and for same and opposite-sex dyads. Results were consistent with those of the analysis of variance with high compatibility correlated with high avoidance of hostility for male therapists. Unique results emerged for female therapists counseling female clients as compatibility in the need area of affection emerged as an important variable.

It was concluded that the results do not fit with expectations derived from sex-role stereotypes and lend no support to allegations that sexism influences therapy. Few parallels can be found in the existing literature on research in psychotherapy.

CHAPTER I
INTRODUCTION

Sex-Roles In Society

The past decade has seen an increasing volume of literature in the social sciences focusing on sex-roles in contemporary society. The emphasis in this area, particularly from feminists' quarters, has been to highlight the pervasive conditioning in our culture that promotes different behavioral norms and expectancies for women and men. This represents a shift away from viewing sex differences from a developmental, biological point of view and to a large extent can be seen as a reaction to the more traditional personality theories that have been so strongly influenced by Freud's now infamous dictum that "anatomy is destiny." Freud viewed penis envy as the source of a basic sense of inferiority in women that led to constitutionally determined feminine traits such as passivity, submissiveness, dependency, narcissism, and masochism (Freud, 1925). Classical psychoanalytic theory views it as pathological for women to display "masculine" behaviors such as aggression. This phallocentric orientation in Freudian theory, which emphasizes the male as the model of normalcy, has had an enormous influence in personality theories and in sex-role stereotypes (Levine, Kamin, & Levine, 1974; Mednick & Weissman, 1975).

The biological bases in which most of these traditional theories were rooted made the resultant personality differences appear to be immutable. As the personality theories became more cognizant of social

and cultural influences, however, the outcome for women remained essentially unchanged. The cluster of behavior and personality traits used to describe women that emerges from the socio-cultural personality theorists overlays to a great extent those described by the Freudian influenced theorists. Though the socio-cultural forces involved here are not as immutable as human biology and anatomy, the pervasiveness of this form of conditioning creates a tremendous obstacle for those who seek to modify the effects of sex-role stereotyping. The list of socio-cultural institutions that seem to perpetuate these stereotypes includes the educational system, the medical profession, children's literature, the mass media, language styles, and the job market (Mednick & Weissman, 1975).

The work of Broverman, Vogel, Broverman, Clarkson, & Rosenkrantz (1972) is perhaps the most publicized and influential reference in the study of sex-role stereotypes. They documented pervasive stereotypic thinking about sex roles that assigns a far greater number of desirable personality traits to men than to women. Furthermore the positively-valued masculine traits formed a competence cluster while the positively-valued traits for women clustered around warmth and expressiveness. Other researchers, amplifying this theme, offered ample documentation for the belief that, in our culture, women are inadequately socialized for independence and are not allowed to develop adequate mastery skills (Hoffman, 1972). The achievement behavior that women do display is motivated by a drive to please rather than to succeed and that success and affiliation are in reality often incompatible. This affiliation-achievement conflict is very basic in sex-role stereotypes and contributes to the fear of success syndrome which leads women to avoid success and

achievement because of the expected negative consequences contingent upon trespassing sex-role boundaries (Horner, 1972).

Women are doubly jeopardized by sex-role stereotypes. First, women are conditioned to assume passive, dependent, and submissive roles which are unadaptive to achieving success in this society. These personality traits are also seen as less desirable than the aggressive, independent achievement oriented behaviors that are encouraged for males within the culture (Rosenkrantz, Vogel, Bee, Broverman, & Broverman, 1968). However, women who assume these "masculine" role behaviors are penalized in various ways. The results of one study indicated that popularity ratings and perceived psychological adjustment of both passive-dependent men and aggressive-assertive women were adversely affected (Maracek, Costrich, Feinstein, Kidder, & Pascale, 1975). Women and men who attempt to move beyond the restrictive stereotyped sex-roles are often rejected and considered maladjusted or even sick. If women attain any of the rewards that society grants to men who behave in assertive aggressive ways, it is often at the cost of much emotional turmoil and conflict which may often lead to emotional problems (Gove & Tudor, 1972). A review of mental health statistics from the United States and Canada highlights the higher incidence of psychiatric disorders and symptoms in female populations as opposed to comparable male populations (Levine, Kamin, & Levine, 1974).

Sex-Roles Stereotypes Among Mental Health Professionals

Since women may enter psychotherapy as a response to the emotional problems engendered from sex-role stereotypes it is crucial that we elucidate how these stereotypes might affect the process of therapy. How are mental health professionals, psychotherapists in particular,

influenced by sex-role stereotypes? Are psychotherapists able to offer a constructive relationship to women or are they influenced by stereotypes to the extent that therapy maintains the behavior it should be trying to change? There has been a good deal of literature that indicts psychiatry and psychotherapy as being sexist in nature, adhering to male-supremist, authoritarian roles which in fact promote the inequality of sex-roles within the therapist-patient relationship (Chesler, 1972; Friedan, 1963; Greer, 1970; Millet, 1970).

Chesler is perhaps the most acerbic in her attack against the mental health profession. She argues that the therapist-patient relationship in fact operates to maintain passive, compliant behavior in women in order to promote a male sexist hegemony. Such polemics, originating within the Women's Liberation Movement have begun to be reflected in the professional liaterature in the social sciences (Kronsky, 1971; Rice & Rice, 1973; Stevens, 1971; Wesley, 1975). Most of these articles analyze the view of women contained within various theories of psychotherapy and call for reform, suggesting changes within the professions and offering alternatives to women who desire treatment. However, empirical studies operationalizing and documenting how sex-role stereotypes operate within the institution of psychotherapy have been slower to emerge.

The first step has been to demonstrate empirically that mental health professionals hold stereotypic sex-roles that are biased against women. An early study (Neulinger, 1968) asked a group of psychologists to rank order 20 paragraphs describing Murray's manifest needs first for an optimally integrated male and then for an optimally integrated female. Results revealed that males were scored higher in dominance and achievement and females were higher in affiliation and

nurturance. The landmark study here was that of Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel (1970). They found that clinical judgments of mental health were influenced by the sex of the person being judged and that this difference parallels stereotypic sex-role differences. Moreover clinicians were revealed to hold a "double standard" of health for men and women in that the behaviors and characteristics judged healthy for an adult, sex unspecified, which are presumed to reflect an ideal standard of health were judged healthy for men but not for women. Healthy women, according to the clinicians, differed from healthy men by being "more submissive, less independent, less subjective, less aggressive, less competitive, more excitable in minor crises, more emotional, more conceited about their appearance, and having their feelings more easily hurt" (p. 6). It was found that women clinicians held these stereotypes to the same extent as male clinicians. The authors conclude that adherence to sex-role stereotypes on the part of the clinicians serves to perpetuate the stereotypes. They further caution therapists that endorsing sex-role stereotypes may be counter-therapeutic in that it reinforces social and intrapsychic conflict. This view is shared by other authors (Fabrikant, 1974).

These results become more complicated when the sex of the clinician making the judgments is taken into consideration. The question asked in a number of studies was essentially: Do women clinicians hold sex-role biases that discriminate against women to the same extent that male clinicians do? Abramowitz & Abramowitz (1973) reported two studies in which women were shown to discriminate against women more than men did. Professional counselors attending a regional APA convention were given bogus case histories which were identical except for the sex of the

subject. When asked to rate the psychological adjustment of the subjects, it was found that female counselors judged women more sternly than did their male colleagues. A recent study evaluated mental health standards among counselors in training and found that in this population women held nearly uniform standards for males, females, and adults, sex unspecified, but male counselors held double standards which reflected sex-role stereotypes (Maslin & Davis, 1975). Women therapists also were revealed to hold more contemporary attitudes towards women than male therapists, who were defined as being more traditional on the basis of a questionnaire developed by the researchers (Brown & Hellinger, 1975). The traditional orientation views women as "defined by her anatomy and . . . as passive and submissive" (p. 266). The "contemporary" orientation is not clearly defined in this study other than being at the opposite end of the continuum from "traditional." The authors' hypothesis that male therapists have attitudes toward women that tend to be more traditional than contemporary was not supported as the males' scores were normally distributed. The authors concluded that this reflects males' ambivalent attitudes towards women and their need to maintain a position of dominance and control.

Results of studies in this area are far from consistent. An extension of one study cited above (i.e., Neulinger, 1968) examined differences in evaluations of optimally integrated males and females made by male and female therapists and found a strong agreement between the male and female clinicians, as well as agreement in the description of the sexes (Neulinger, Stein, Schillinger, & Welkowitz, 1970). Haan and Livson (1973) found no clear differences in assessments of male and female subjects made by male and female examiners. There was a tendency

for males to rate more harshly overall and for females to rate more positvely. Recent research on sex-role stereotypes of psychotherapists has also found no support for a bias against women in mental health professionals and also no differences based on sex of the person making the judgments (Maxfield, 1976; Oppendisano-Reich, 1976).

What is still noticeably lacking in the research literature are investigations to determine how sex-role stereotypes affect the process of psychotherapy. We have reviewed literature documenting the existence of sex-role stereotypes among mental health professionals but there has been no research which illustrates how the presence of stereotypes affects the behavior of therapists and alters the process of therapy.

Therapy Process Studies of Hostility and Dependency

Two traits, aggression and dependency, emerge consistently in the literature on sex-roles. These traits lie at the core of sex-role stereotypes and are curcial in differentiating typically "masculine" behavior from typically "feminine" behavior. There exists within the body of research on the process of psychotherapy a methodology which addresses itself directly to therapists' handling of these behaviors. The first of these studies (Bandura, Lipsher, & Miller, 1960) focused on therapists' responses to hostility expressed by their clients and what effect the therapist response had on subsequent client behavior. They hypothesized that therapists' approach responses would act as positive reinforcement causing the client to continue expressing feelings of hostility. Conversely, avoidance by the therapist would serve as negative reinforcement which would decrease or inhibit further expression

of hostility on the part of the client. This prediction was clearly supported. Direction of the clients' expressed hostility emerged as a critical factor since therapists were more inclined to avoid hostility that was directed at them rather than at others. A later researcher in this group extended these findings derived from early sessions of treatment to the entire course of long-term treatment (Varble, 1968). He replicated the finding that therapists' approach responses elicit further expressions of hostility while avoidance discourages the client from continuing to express hostility. He did not find that approach has a reinforcing value since the amount of client expressed hostility decreases over time in treatment. Experienced therapists approached hostility directed at them less than inexperienced therapists did.

Therapists' responses to client initiated hostility has been investigated with a variety of experimental paradigms. Using a modification of the Bales Interaction Process Analysis Categories, Gamsky & Farwell (1966, 1967) found that client hostility directed toward the therapist evoked greater negative reactions than hostility directed towards others. They found that therapist sex had no significant effect on response to hostility but client sex did. With the male hostile clients as opposed to the female hostile clients, therapists used more tension release, agreement, reflection, requests for information, and elaboration, but less disagreement. The researchers speculated that when faced with direct client hostility, therapists use responses that deter the client from further expressions of hostility but experienced counselors do so less than inexperienced counselors. Other studies have determined that hostile client behavior induces anxiety in therapists (Russell & Snyder,

1963) and that hostile client behaviors elicits counter-hostility on the part of the therapists (Heller, Myers, & Kline, 1963).

A study using the same verbal conditioning paradigm (Bandura et al., 1960) substituted dependency for hostility as the client behavior under investigation (Winder, Ahmad, Bandura, & Rau, 1962). The results paralleled those of the first study with clients continuing dependency statements significantly more after approach than after avoidance by the therapist. They also found that therapists' approach to client expressions of dependency was positively related to clients remaining in treatment. Patients terminated treatment more often when their dependency statements were avoided by the therapists. The authors concluded that "management of expressions of dependency is the critical feature related to remaining in treatment" (p. 133). Another study attempted to distinguish between the elicitation versus reinforcement value of therapists' approach-avoidance responses (Caracena, 1965). The author argues that in the earlier studies "reinforcement effects were not tested because there were no measures of change in the probability that clients continue or discontinue discussion of the topic as a result of therapists' approach and avoidance. Evidence that stimuli elicit responses does not attest to whether they reinforce" (p. 268). The finding that a specific event occurs more often after approach as opposed to avoidance by the therapist does not constitute proof that learning in operant conditioning terms has occurred.

Learning in these terms would be manifested as an increased probability of a given event occurring following approach (reinforcement) by the therapist over the course of therapy. The results of this study support the effectiveness of approach and avoidance as <u>elicitors</u> but not

as reinforcers of client behaviors. This study failed to replicate the earlier finding that remaining in treatment was contingent upon therapists approaching dependency. The hypothesis that experienced therapists would approach dependency more than inexperienced therapists was not supported.

Another investigator studied the effects of therapists' approach and avoidance on clients expressions of dependency over long-term therapy (Schuldt, 1966). The results indicated that the elicitation effects mentioned above occur reliably regardless of the stage of therapy being investigated. He found that therapists are consistent in their rate of approach throughout the course of therapy. Therapists approach dependency more when it was directed at them but there was no difference between experienced and inexperienced therapists in rate of approach. Clients were found to initiate significantly more dependency responses in the initial sessions of treatment than during the later sessions. The effectiveness of approach as an elicitor of dependency responses decreased over time. A similar finding was reported by Caracena (1965) who spoke of a regression toward the mean, from the first to the second therapy segments, on the probability of patients continuing dependency statements following approach by the therapist.

One study related counselors approach to client expressed hostility and dependency and counselors liking of clients to counselors measured needs for affiliation and nurturance (Mills & Abeles, 1965). They found that approach to hostility was related to counselor needs for nurturance and affiliation but approach to dependency was not related to either. They explained this somewhat surprising finding as due to the stage of therapy that was sampled, i.e., 5th sessions. They assumed that the

dependency needs of the clients had been met in earlier sessions and resolved, but hostility was still emerging as an area to be dealt with in therapy. A previous study by this author found that hostile clients elicited higher levels of emphatic understanding than dependent clients with therapists in training (Keroack, 1971).

Therapists' directiveness was found to be related to client behaviors in a number of studies. Reflective as opposed to leading therapists were found to elicit fewer dependency statements from clients in the initial interview (Rottshafer & Renzaglia, 1962). Therapists were more directive with dependent clients as opposed to hostile or normal clients in a number of analogue studies (Bohn, 1967, 1965; Heller, Myers, & Kline, 1963). Directiveness was found to decrease with experience and training, however. Bohn concludes that "dependency and hostility have been shown again to be two aspects of a client's behavior which can produce demonstrable effects on the therapist's performance" (1967, p. 198). None of these studies report results for different sex clients. Thus we do not know if client sex per se can contribute to these different therapist behaviors.

Operational Definition of Sexism in Therapy

The research methodology described above which was first used by Bandura et al. (1960) and subsequently by Winder et al. (1962), Caracena (1965), Schuldt (1966), and Varble (1968) seems remarkably well-tailored for investigating sexism in psychotherapy. As we have seen, the behaviors involved, dependency and hostility, are central to sex-role stereotypes and are critical in distinguishing between "masculine" and

"feminine" behavioral stereotypes. Dependency and passivity or submissiveness are considered to be "feminine" behavior traits, while the opposites, independence and aggression are held to be typically "masculine" behaviors. We have also seen how these behaviors are very important variables in the process of psychotherapy. We can thus construct an operational definition of sexism in psychotherapy. A therapist operating from within the confines of sex-role stereotypes would approach dependency and avoid hostility in female clients but avoid dependency and approach hostility in male clients. Such therapist behaviors would maintain the sex-role stereotypes that are present in society and thus may increase the social alienation and psychic turmoil that these biases create in women. It is important to point out that a sexist orientation must include both the approach to dependency and the avoidance of hostility. Approaching dependency may be sound therapeutic technique since that is where many of the conflicts for clients in therapy may be and that is where the work in therapy must be focused. However, approaching dependency while avoiding hostility in women clients may communicate to the client that aggressive behavior is unacceptable or inappropriate. It promotes a unilateral view of women which parallels sex-role stereotypes and offers no opportunity for women to work on aggression in therapy. It will also be revealing to look at therapists' differential responses to male and female clients. It is possible that therapists, from theoretical orientation or personal idiosyncracy, might typically approach one kind of behavior or avoid others. However, if this pattern of approach and avoidance changes with different sex clients, one might legitimately question whether a sex-role stereotype is operating here.

The specific hypotheses to be tested in this part of the study will be

H_1 Therapists will approach dependency more than hostility in female clients.

H_2 Therapists will approach dependency more than avoid it in female clients.

H_3 Therapists will avoid hostility more than approach it in female clients.

H_4 Therapists will approach hostility more than avoid it in male clients.

H_5 Therapists will approach dependency more than avoid it in male clients.

H_6 Therapists will avoid dependency more than hostility in male clients.

H_7 Therapists will approach dependency more in female clients than in male clients.

H_8 Therapists will avoid hostility more in female clients than in male clients.

Therapist-Client Compatibility and Therapy Process

It has been widely recognized by many theorists and researchers in psychotherapy that the relationship between the therapist and the client is one of the most potent factors influencing the outcome as well as the process of the therapy. Consequently there has been a significant interest in matching the client with the therapist on various criteria intended to optimize the effectiveness of the therapeutic interaction. Most often the match has been determined on the basis of personality

variables of the therapist and the client and the rationale for these studies is very varied and the results often seemingly contradictory. Studies which have investigated the effects of therapist-client similarity on various outcome measures of psychotherapy have demonstrated no relationship (Schopler, 1958), a positive linear relationship (Tuma & Gustad, 1957; Axelrod, 1970; Heines & Trosman, 1960; Mendelsohn & Geller, 1963), a negative relationship (Lesser, 1961; Snyder, 1961), and a curvilinear relationship (Gerler, 1958; Carson & Heine, 1962; Mendelsohn & Geller, 1965). Proponents of the curvilinear relationship between therapist-client similarity and success of treatment argue that too great similarity of personality causes the therapist to over-identify with the patient and his problems, thus reducing objectivity and impeding progress. Lack of any similarity makes it difficult for the therapist to empathize with the client or understand his problems (Meltzoff & Kornreich, 1970).

A number of studies have matched therapists and clients on the basis of interpersonal compatibility as measured by the Fundamental Interpersonal Relations Orientation Behavior (FIRO-B) scale (Schutz, 1958). Matching made with the FIRO-B has greater implications for psychotherapy since this test was especially designed for use in the study of interactions between two or more people. Matching on compatibility is much less simplistic than matching on the basis of similarity. Compatibility as measured by the FIRO-B takes into account similarity in three interpersonal need areas, inclusion, control, and affection, and in addition, includes a measure of complementarity with regard to how much each member of the dyad wishes to originate or receive behavior in the three need areas. The usefulness of this test and the concept of interpersonal compatibility as a basis for matching therapist-client dyads has been validated in a number of studies.

Sapolsky (1960) used the FIRO-B to establish compatible and incompatible dyads and then assessed what effect this matching had on verbal conditioning. His findings have great implications for the present study. He found that incompatibility in terms of interpersonal needs diminished the effectiveness of verbal conditioning. He concluded that subtle verbal reinforcers emitted by the therapist are likely to be effective only when compatibility with the client is high. A later study by the same author found that, for female patients, compatibility between doctor and patient was positively correlated with outcome (Sapolsky, 1965). This was due to the fact that patients felt more similar to and better understood by their doctors when compatibility was high. Another study found that compatibility significantly affected the therapist's and the patient's evaluation of each other but did not influence the effectiveness of therapy (Gassner, 1969). After three and eleven weeks in treatment patients held more favorable views of their therapists when compatibility was high. Therapists preferred high-compatibility patients after three weeks but not after eleven weeks. A study using various types of compatibility scores derived from the FIRO-B found significant correlations between these scores and therapy outcome as measured by client evaluation (Mendelsohn & Rankin, 1969). These investigators also found striking differences between the correlations for male and female clients. Overall, compatibility was a poor predictor for male clients but a good one for female clients. The authors summarize their results as indicating that "compatibility in inclusion and affection need areas is associated with less client satisfaction, lower evaluation of the counselor, and less comfort and rapport on the part of the client. The expected (positive) relationship between compatibility and outcome was

found only in the control need area" (Mendelsohn & Rankin, 1969, p. 161). This study is very significant for a number of reasons. First, the authors display a comprehensive understanding of the variety and complexity of scores obtained from the FIRO-B, as well as a keen awareness of the implications of using compatibility scores as a basis for matching. They provide correlations between outcome of therapy and all of the ten possible compatibility scores. They have thus taken full advantage of the data available from the FIRO-B. Perusal of their results reveals significant correlations for each of the three types (reciprocal, originator, and interchange) of compatibility scores possible in Schutz's system as well as significant correlations in each of the three need areas.

Two of these significant correlations are located in both the inclusion and control need areas with one significant correlation in the affection need area. Secondly, they compare the results for males with the results for females which leads them to conclude that therapist-client matching on the basis of compatibility is more effective for female clients. They reason that this is due to the well-documented finding that "compared to males, females are more sensitive and responsive to interpersonal behavior and more dependent on others" (p. 162). Though they fail to report the findings for same versus opposite sex dyads they do mention in a footnote that such analyses were performed and revealed no significant difference between same-sex versus opposite sex client-therapist pairs.

Two need areas, inclusion and control, would seem to be especially potent variables affecting the process of psychotherapy, especially during the initial stages. We also feel that of the three compatibility measures

available from the FIRO-B, reciprocal compatibility is the most appropriate for the present study. Reciprocal compatibility is said to exist when the expressed behavior of one member of a dyad equals the wanted behavior of the other member and vice versa. We will hypothesize that a high degree of reciprocal compatibility between therapist-client dyads will have a potentiating effect upon possible sexist biases operating during the therapy session. More specifically we will test the following hypotheses:

H_9 With female clients, therapists will approach dependency more when compatibility is high than when it is low.

H_{10} With female clients, therapists will avoid hostility more when compatibility is high than when it is low.

H_{11} With male clients, therapists will approach hostility more when compatibility is high than when it is low.

CHAPTER II
METHOD

Subjects. There were two groups of subjects for this experiment. One group consisted of ten licensed psychologists, five males and five females, each of whom are practicing psychotherapists with at least five years of experience, post-degree. This group is labelled as therapists in this study. The other group of subjects consisted of forty undergraduate students, twenty males and twenty females, from the University of Florida subject pool. They were the clients in this study.

Apparatus. Apparatus used included video-tape recording equipment, a casette audio-tape recorder for use in transcribing, and an interview room equipped with a one-way mirror, through which the video-tape recording was done.

The FIRO-B scale (Schutz, 1958) was designed to measure three interpersonal need areas: Inclusion, control, and affection. The need for inclusion is expressed as wanting to be attended to or to attract attention and interest. The goal is to establish and maintain satisfactory relations with people with respect to interaction and association. The need for control involved on one hand influence, leadership, power, coercion, authority, superiority, and independence, and on the other hand dependency, rebellion, resistance, and submission. The goal is to establish and maintain a satisfactory relation with people with respect to control and power.

Since scores for affection were not used in this study we will omit any discussion of this need area. The FIRO-B scale consists of 54 multiple choice questions designed to measure the amount of expressed and desired behavior within each need area for an individual. Schutz has developed formulae for determining interpersonal compatibility within a dyad from their scores on the FIRO-B. He defines compatibility as "a property of a relation between two or more persons . . . that leads to mutual satisfaction of interpersonal needs and harmonious coexistence" (Schutz, 1958, p. 105). Compatibility is a function of similarity and complementarity. The more similar two people are in the relative importance they place on the specific need areas the more compatible they will be. But compatibility also requires that the two people be complementary in regards to expressing and receiving behavior in the specific need area. There are three kinds of compatibility scores in Schutz's system, reciprocal, originator, and interchange compatibility. The one used for matching therapist-client dyads in this study, reciprocal compatibility, is defined as existing when the expressed behavior of one member of a dyad equals the wanted behavior of the other member and vice versa.

Procedure. The therapy video-tapes used in this study are from a data pool collected at the University of Florida as part of a research project on psychotherapy (Goldman, Jones, Pence, Shilling, Thomas, & Fennell, 1977).

The therapists used in this study were from the area and volunteered to participate in the project. They were administered the FIRO-B and their scores in the need areas of inclusion and control were calculated. They were informed that they would conduct one therapy interview with each of four undergraduate students who had agreed to participate in an experiment entitled "An analogue study of counseling." They were also

informed that the students had been told to select a real problem that they had that they would be willing to talk about during one session with a professional therapist. Therapists were also informed that the session would be video-taped and that the students could be referred to one of several local facilities for further counseling if they felt this was indicated.

The clients were selected from a larger group of undergraduate students who had responded to a notice on the Psychology Department bulletin board. All students who responded were administered the FIRO-B and the combined reciprocal compatibility scores on inclusion and control were computed for all therapist-student dyads. The forty students used as clients were selected because they formed a high or low compatibility match with one of the therapists in the experiment.

Each therapist was paired for an interview with one high-compatibility same-sex client and one high-compatibility opposite-sex client as well as one low-compatibility same-sex client and one low-compatibility opposite-sex client. A high-compatibility client was operationally defined as a student whose combined reciprocal compatibility score with a particular therapist fell within the bottom 5% of all students' compatibility scores with that therapist. A low-compatibility client was a student whose compatibility score with a particular therapist fell in the top 5% of all students scores with that therapist. Students meeting the criteria were contacted by phone and informed that they had been selected for use in the study and were told to select a real problem they had that they would be willing to discuss with a professional therapist during one video-taped interview.

At the time of the interview the therapist and client were informed by one of the research associates that they would have 50 minutes in which to talk and that they would be signalled via a knock on the door at the end of 45 and 50 minutes. The researchers video-taped the interview from an adjoining room from which the interview could be observed via one-way mirror.

The forty interview tapes were condensed into master tapes which consisted of three three-minute segments from the original complete tapes. The segments consisted of the first three minutes of the interview, three minutes from the middle, and three minutes from the final stages of the interview. The segments from within each interview were randomized on the master tapes. Detailed rules for determining the segments are found in Appendix A. The randomized three-minute segments were re-recorded onto audio tapes for use in transcribing. Transcripts were made following the rules for typists described in Gottschalk, Winget, & Gleser (1969).

Rating Procedure

The rating procedure used is a modification of that designed by Bandura, Lipsher, & Miller (1960). The complete scoring manual is included in Appendix B. The unit considered consists of the total verbalization of one speaker bounded by the preceding and succeeding speeches of the other speaker, with the exception of interruptions.

In this system all client statements are assigned to one of three categories: 1) Dependency, which includes the following verbal expressions: Help seeking, approval seeking, company seeking, information seeking, agreement with another, concern about disapproval, and initiative seeking; 2) hostility, which includes: Expressions of anger, dislike, resentment, antagonisms, opposition, and hostility; and 3) other, any verbalizations that do not fall into categories 1 or 2 above. For this

study the interaction sequence examined consisted of the clients' statement of dependency or hostility and the following therapist response.

The therapist responses were scored as either approach or avoidance. An approach response is defined as any verbalization by the therapist which seems designed to elicit from the client further expression or elaboration of the dependent or hostile feelings, attitudes, or actions described or expressed in the clients' immediately preceding statement. Subsumed under the generic term approach are the following categories of therapists's responses: 1) Approval; 2) exploration; 3) reflection; 4) labelling; 5) interpretation; 6) generalization; 7) support; and 8) factual information.

An avoidance response is any verbalization by the therapist which seems designed to inhibit, discourage, or divert further expression of the dependent or hostile feelings, attitudes, or behaviors expressed in the client's immediately preceding statement. Subcategories of behavior considered as avoidance include: 1) Disapproval; 2) topic transition; 3) ignoring; and 4) mislabelling.

All rating judgments for client and therapist statements were made on the basis of explicit verbal content. Raters worked from typed transcripts of the master tapes.

Two raters were trained in the use of this scoring system. Training materials included transcripts of therapy interview taken from various textbooks on psychotherapy. The raters were friends of the experimenter both of whom are professionals in health related fields but were not at the time associated with the University. All therapists and client names were deleted from the transcripts and raters were given no information about the transcripts other than identifying them as segments of therapy

interviews. All training was done by the experimenter and the general training format consisted of a didactic session defining the categories and subcategories on which client and therapist statements were judged as well as definitions of units and interaction sequences. Examples from the training manual were discussed. At no point during the training session was any information about the design or research hypotheses shared with the raters. Next training transcripts were openly rated and any discrepancies were discussed. This was followed by a series of training sessions in which the raters scored each transcript independently but then discussed any discrepancies in scoring afterwards. Rater agreement was judged on unit and interaction sequences and on the major categories of client behaviors (i.e., dependency, hostility, and other) and therapist behavior (approach and avoidance). During the training trials the raters were asked to indicate which subcategory, within the major categories, a response belonged to. This was to help clarify the discrepancies in scoring as well as to keep the judges oriented to the specific behavioral definitions that the subcategories provide. In the actual scoring raters indicated only the major categories.

A number of modifications in the scoring manual evolved as a result of the training sessions. The first subcategory under Dependency reads "Problem description: States problem in coming to therapy, gives reason for seeking help. . . ." Because of the design of this study in which patients were explicitly instructed to bring a problem to talk about, the initial problem descriptions by clients were not scored as dependency. It was felt that the instructions here made these expressions of dependency artificial. Subsequent spontaneous statements of problems were scored as dependency.

Further discrimination was required for the subcategory of Dependency labelled "Agreement with another:" The additional direction was given to raters not to score as dependency clients' affirmative responses to therapists' non-interpretive question which demand a "yes" or "no" answer.

The original manual lists Silence as a subcategory of therapists' Avoidance behavior, which is scored after the therapist makes no response within five seconds after the client stops talking. Since transcripts were used in this study this category was inappropriate.

Finally scoring of the subcategory Critical Attitudes under Hostility was altered from the original manual by instructing the raters that critical attitudes about the self were not to be scored as hostility. It was felt that negative self-references or self-demeaning attitudes do not reflect the concept of hostility that was being investigated.

Training was considered successful when the judges attained a rate of disagreement of less than ten percent for both therapist and client variables on a sample of 100 interaction sequences. Raters quickly achieved perfect agreement in determining units and interaction sequences.

Each rater then independently scored 20 of the 40 interviews. As a final check in inter-rater agreement each rater independently scored five interviews that were originally scored by the other rater, yielding a pool of ten mutually scored interviews. Rate of disagreement for client variables was 9.59% (n = 198). Rate of disagreement for therapist variables was 7.57% (n = 132). Again there was perfect agreement in definition of units and interaction sequences.

Inter-rater reliability is reported in this fashion because the basic task of the raters involved making judgments on a nominal scale.

These data were then transformed into interval level data which is the dependent variable of rate.

Rates are ratios determined by dividing the number of times a therapist approached (or avoided) the client's expression of dependency (or hostility) by the total number of expressions of that behavior emitted by the client during that interview. Four rates were computed for each interview: Approach to dependency (ApD); approach to hostility (ApH); avoidance of dependency (AvD); and avoidance of hostility (AvH). Rates of approach may be greater than one since therapists' initiation of discussion about a behavior was scored as an approach thus the number of approaches may exceed the number of expressions of that behavior. Inter-rater reliability for the rate scores was also computed. Pearson product-moment coefficients computed from the pool of ten mutually scored interviews were all statistically significant ($p < .02$). They were ApD, $r = .91$; ApH, $r = .79$; AvD, $r = .88$; and AvH, $r = .73$.

Data Manipulations

In instances where there were no expressions of hostility or dependency by the client but there were initiations of discussion on these topics by the therapists rates would be impossible to determine since we would have a ratio where the denominator is zero. Where this occurred the denominator was arbitrarily assigned a value of one, the smallest number which allows computation of the rate.

There were some scores missing in ten of the interviews. This occurred when there were no client expressions of either dependency or hostility and also no initiation of discussion on these topics by the therapists. In all ten cases missing scores were for rates of dependency

or hostility only, never for both. Thus each interview yielded some scores relevant to this study; so rather than discard interviews, the mean rate score for that cell was used in the analyses. Thus where the rate of ApD was missing from an interview with a male therapist and male client matched for low-compatibility, the score used was the mean rate of ApD of the three other interviews within that cell (i.e., male therapist, male client, low compatibility). This procedure also has the advantage of maintaining equal n's in all cells thus facilitating statistical analysis.

CHAPTER III
RESULTS

The data were analyzed using an analysis of variance with a 2 x 2 x 2 x 4 split-plot repeated measures design. There were two levels of therapist sex, two levels of client sex, two levels of compatibility, and four rates (ApD, ApH, AvD, AvH). Inclusion of rates as an independent variable in the design enabled one to assess variances among the four different rates as well as interaction effects between the different rates and the other independent variables.

Some of the conditions normally required for use of analysis of variance, such as homogeneity of variance and normal distribution of scores, were not met by these data. However there is ample justification for use of this statistic where there is an equal number of observations in each cell (Kirk, 1968, p. 61). Means for all dependent variables within each cell are presented in Appendix C.

Results of Anova for Experimental Hypotheses

The analysis of variance procedure failed to support any of the hypotheses of this experiment. All of the hypotheses presumed that client sex would significantly affect the variance in the dependent variable. As we can see in Table 1 client sex is not a significant variable either simply or in interactions with therapist sex and compatibility.

TABLE 1

ANALYSIS OF VARIANCE WITH FOUR INDEPENDENT VARIABLES AND RELATED INTERACTIONS

SOURCE	df	SUM OF SQUARES	F RATIO	p
1. RATE	3	4.8001	10.81	*
2. RATE X THERAPIST SEX	3	0.8527	1.92	NS
3. RATE X CLIENT SEX	3	0.4807	1.08	NS
4. RATE X COMPATIBILITY	3	1.5564	3.50	*
5. RATE X THERAPIST SEX X CLIENT SEX	3	0.2039	0.46	NS
6. RATE X THERAPIST SEX X COMPATIBILITY	3	1.4778	3.33	*
7. RATE X CLIENT SEX X COMPATIBILITY	3	0.7143	1.61	NS
8. RATE X THERAPIST X CLIENT X COMPATIBILITY	3	1.1279	0.29	NS
9. ERROR VARIANCE (RATES ONLY)	96	14.2123		
10. THERAPIST SEX	1	0.0198	0.25	NS
11. CLIENT SEX	1	0.0211	0.27	NS
12. COMPATIBILITY	1	0.2160	0.28	NS
13. THERAPIST SEX X CLIENT SEX	1	0.0722	0.93	NS
14. THERAPIST SEX X COMPATIBILITY	1	0.1600	2.06	NS
15. CLIENT SEX X COMPATIBILITY	1	0.0490	0.63	NS
16. THERAPIST SEX X CLIENT SEX X COMPATIBILITY	1	0.2283	2.94	NS
17. ERROR VARIANCE WITHIN GROUPS	32	2.4851		
TOTAL	159	27.4832		

*$p < .05$

NOTE: Sources 10-16 used pooled error term = .13
Sources 1-8 used error term = .15

Comparison of the mean rates obtained in this experiment with the hypothesized relationships reveals some trends in the predicted direction (see Table 2).

Graphic display of approach rates for male and female clients with the variables of therapist sex and compatibility taken into account does reveal some interesting trends which however failed to achieve statistical significance. Figure 1 depicts a tendency for both male and female therapists when matched with high-compatibility clients, to approach dependency less with female clients than with male clients. The complementary trend is also noted in Figure 1 in which both sex therapists avoid dependency more with female clients as opposed to male clients. This tendency is opposite to H_7 which predicted higher rates of approach to dependency with female clients than with male clients.

When sex of the therapist is disregarded therapists approach hostility equally with low-compatibility male and female clients. However, when sex of the therapist is considered, a tendency is seen for male therapists to approach hostility more in male clients than in female clients, which corresponds with H_8 (see Figure 2). This tendency is reversed for female therapists and for both sex therapists when matched with high-compatibility clients (see Figure 2).

Significant Results from Anova

The split-plot analysis of variance procedure did yield significant results for the variable rate, as well as a significant effect for the interactions of rate by compatibility, and also for rate by compatibility by therapist sex (see Table 1). Results of analyses for simple effects within this highest-order interaction effect will be examined in turn.

TABLE 2
COMPARISON OF MEAN RATES OBTAINED WITH HYPOTHESIZED RELATIONSHIPS

CLIENT SEX	HYPOTHESIS	RESULTS OBSERVED	HYPOTHESIZED DIRECTION
FEMALE	H_1: ApD > ApH	ApD = .73; ApH = .57	YES
"	H_2: ApD > AvD	ApD = .73; AvD = .39	YES
"	H_3: ApH < AvH	ApH = .57; AvH = .63	YES
"	H_9: $ApD^h > ApD^l$	$ApD^h = .75$; $ApD^l = .73$	?
"	H_{10}: $AvH^h > AvH^l$	$AvH^h = .78$; $AvH^l = .48$	YES
MALE	H_4: ApH > AvH	ApH = .50; AvH = .65	NO
"	H_5: ApD > AvD	ApD = .94; AvD = .32	YES
"	H_6: AvD > AvH	AvD = .32; AvH = .65	NO
"	H_{11}: $ApH^h > ApH^l$	$ApH^h = .29$; $ApH^l = .70$	NO
MALE VS FEMALE	H_7: $ApD^f > ApD^m$	$ApD^f = .73$; $ApD^m = .94$	NO
	H_8: $AvH^f > AvH^m$	$AvH^f = .63$; $AvH^m = .65$	?

h = high compatibility dyad

l = low compatibility dyad

f = female client

m = male client

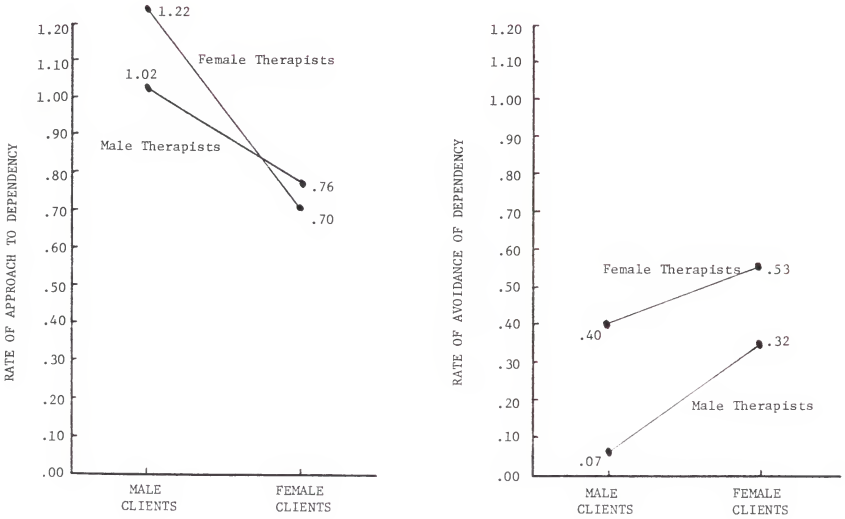


Figure 1. Graphs of rates of approach to dependency and avoidance of dependency by client sex in high compatibility dyads.

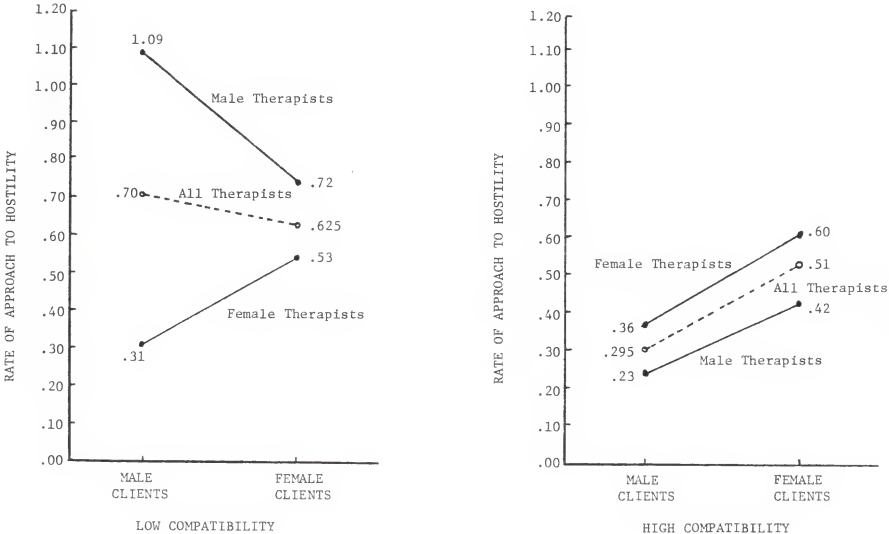


Figure 2. Graphs of rate of approach to hostility by client sex in low compatibility and high compatibility dyads.

Results for Different Rates

Results of analyses of variance at each of the four different rates are summarized in Table 3. The rate ApD is not significantly influenced by either of the independent variables of therapist sex or compatibility nor was it influenced by the interaction of these variables.

Rate of ApH is significantly influenced by compatibility and by the interaction of compatibility and therapist sex (see Figure 3). Analysis of simple effects within this interaction indicates that therapist sex significantly influences rate of ApH in low-compatibility dyads but not in high-compatibility dyads. Furthermore differences in compatibility produce significant variances in ApH for male therapists but not for female therapists (see Table 3).

Rate of AvD is significantly influenced by therapist sex only with female therapists avoiding dependency more than male therapists with both high and low compatibility clients.

Rate of AvH is significantly influenced by the dependent variable compatibility only. Hostility was avoided more by therapists as compatibility increased. This effect was due primarily to the male therapists (see Figure 3).

Results by Sex of Therapist

Analyses of the results for male therapists alone revealed a significant variance in the four rates as well as a significant rate by compatibility interaction (see Table 4). Analysis for simple effects within this interaction revealed a significant variance in the rates for both low-compatibility and high-compatibility dyads. Furthermore

TABLE 3
ANALYSIS OF VARIANCE AT EACH RATE FOR COMPATIBILITY AND THERAPIST SEX

SOURCE	df	SUM OF SQUARES	F RATIO	p
at ApD				
1. THERAPIST SEX	1	.019	0.15	NS
2. COMPATIBILITY	1	.329	2.54	NS
3. THERAPIST SEX X COMPATIBILITY	1	.124	0.92	NS
4. POOLED ERROR VARIANCE	128	16.697		
at ApH				
1. THERAPIST SEX	1	.262	2.02	NS
2. COMPATIBILITY	1	.692	5.31	*
3. THERAPIST SEX X COMPATIBILITY	1	1.037	8.00	*
4. POOLED ERROR VARIANCE	128	16.697		
at AvD				
1. THERAPIST SEX	1	.557	4.31	*
2. COMPATIBILITY	1	.030	0.61	NS
3. THERAPIST SEX X COMPATIBILITY	1	.012	0.25	NS
4. POOLED ERROR VARIANCE	128	16.697		
at AvH				
1. THERAPIST SEX	1	.034	0.36	NS
2. COMPATIBILITY	1	.527	4.08	*
3. THERAPIST SEX X COMPATIBILITY	1	.464	3.57	NS
4. POOLED ERROR VARIANCE	128	16.697		

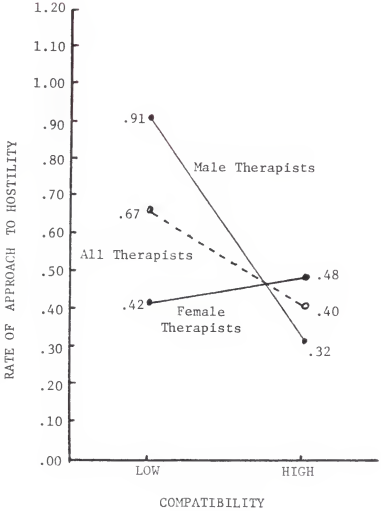
*$p < .05$

Tests for Simple Therapist Sex and Compatibility Effects after Significant Interations

1. THERAPIST SEX @ LOW-COMPATIBILITY	1	1.170	9.00	**
2. THERAPIST SEX @ HIGH-COMPATIBILITY	1	.128	0.72	NS
3. COMPATIBILITY @ FEMALE THERAPIST	1	.017	0.10	NS
4. COMPATIBILITY @ MALE THERAPIST	1	1.71	13.15	**

NOTE: Dependent variable is rate ApH

**$p < .01$



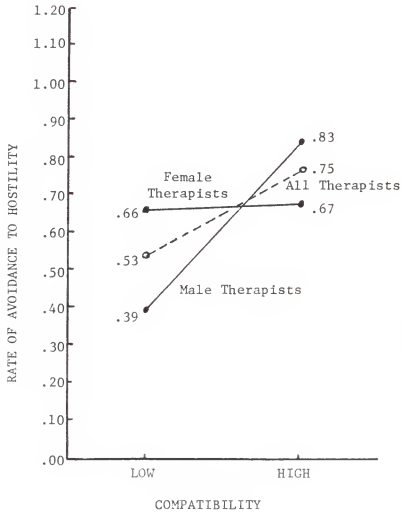


Figure 3. Graphs of rate of approach to hostility and avoidance of hostility by compatibility of dyads.

TABLE 4
ANALYSIS OF VARIANCE AT EACH SEX THERAPIST FOR RATE AND COMPATIBILITY

SOURCE	df	SUM OF SQUARES	F RATIO	p
MALE THERAPISTS				
1. RATE	3	3.901	8.67	**
2. COMPATIBILITY	1	0.032	0.25	NS
3. RATE X COMPATIBILITY	3	2.734	6.07	**
** $p < .01$				
FEMALE THERAPISTS				
1. RATE	3	1.751	3.88	*
2. COMPATIBILITY	1	0.150	1.15	NS
3. RATE X COMPATIBILITY	3	0.300	0.59	NS
*$p < .05$				
Test for Simple Rate and Compatibility Effects after Significant Interation				
1. RATE @ LOW-COMPATIBILITY	3	2.890	6.42	*
2. RATE @ HIGH-COMPATIBILITY	3	3.750	8.33	**
3. COMPATIBILITY @ ApD	1	0.024	0.67	NS
4. COMPATIBILITY @ ApH	1	1.710	13.15	**
5. COMPATIBILITY @ AvD	1	0.040	0.98	NS
6. COMPATIBILITY @ AvH	1	0.990	7.62	**

NOTE: For male therapist only

*$p < .05$

**$p < .01$

NOTE: In all of the above error term for all sources involving rate = .15, all other sources use pooled error term = .13

compatibility significantly influenced the variance in the rates of ApH and AvH but not in ApD and AvD.

Tukey's test of significance was performed to examine differences among the individual rates within each level of compatibility with male therapists and revealed that in low-compatibility dyads ApD and ApH differed significantly from AvD and AvH. In high-compatibility dyads ApD and AvH differed significantly from ApH and AvD (HSD = .45; n = 10).

Analysis of variance results for female therapists only revealed a significant variance among the rates but no significant effect due to compatibility and no compatibility x rate interaction effect (see Table 4). Tukey's test of significance revealed that ApD was significantly different from AvD and ApH but not from AvH (HSD = .32; n = 20). Graphic presentation of rates by compatibility level for each sex therapist are presented in Figure 4.

Results by Compatibility Level

Analysis of variance results for low-compatibility dyads only revealed a significant variance among the rates as well as a significant rate x therapist sex interaction effect (see Table 5). Further analysis of simple effects within this interaction showed that the variance among individual rates was significant for male therapists but not for female therapists. Furthermore therapist sex significantly influenced rate of ApH but not ApD, AvD, and AvH though it approaches significance in this last rate.

Analysis of variance results for high-compatibility dyads alone revealed a significant variance among rates but no effect due to sex of therapist and no rate x therapist sex interaction effect (see Table 5).

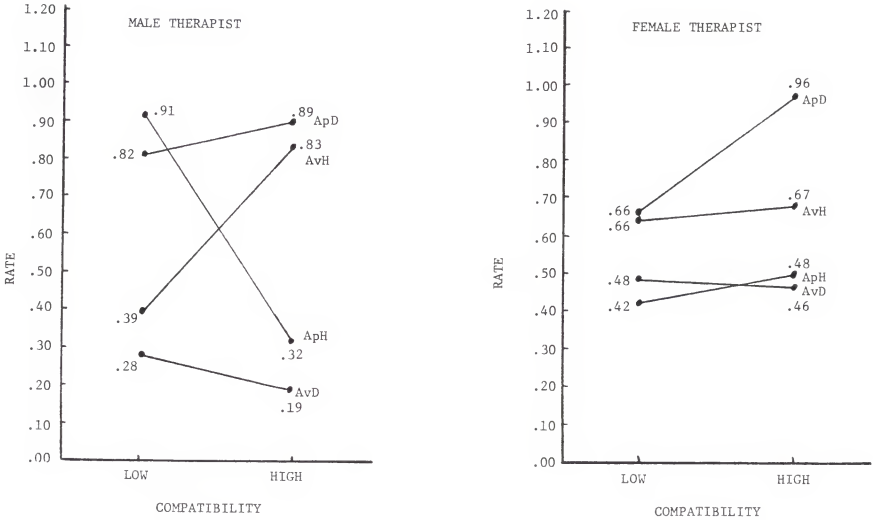


Figure 4. Graphs of all rates by compatibility for male and female therapists.

TABLE 5
ANALYSIS OF VARIANCE AT EACH LEVEL OF COMPATIBILITY FOR RATE AND THERAPIST SEX

	SOURCE	df	SUM OF SQUARES	F RATIO	p
LOW COMPATIBILITY					
	1. RATE	3	1.513	3.36	*
	2. THERAPIST SEX	1	0.034	0.22	NS
	3. RATE X THERAPIST SEX	3	1.835	4.09	*
*p < .05					
HIGH COMPATIBILITY					
	1. RATE	3	4.844	10.77	**
	2. THERAPIST SEX	1	0.146	1.12	NS
	3. RATE X THERAPIST SEX	3	0.495	1.10	NS
**p < .01					
	Tests for Simple Rate and Therapist Sex Effects after Significant Interaction				
	1. RATE @ FEMALE THERAPIST	3	0.460	1.00	NS
	2. RATE @ MALE THERAPIST	3	2.890	6.42	**
	3. THERAPIST SEX @ ApD	1	0.120	1.98	NS
	4. THERAPIST SEX @ ApH	1	1.170	9.00	**
	5. THERAPIST SEX @ AvD	1	0.202	1.55	NS
	6. THERAPIST SEX @ AvH	1	0.375	2.88	NS

NOTE: Low compatibility dyads only

**p < .01

NOTE: In all of the above error term for all sources involving rate = .15; all other sources use pooled error term = .13

Tukey's test of significance revealed that ApD and AvH were significantly different from ApH and AvD (HSD = .32; n = 20). Again the interaction of rate by therapist sex for each level of compatibility are graphically presented in Figure 5.

Exploratory Correlational Analyses

Compatibility has emerged as a highly significant variable in this study so further exploratory analyses were performed. The original sorting of the dyads into high- or low-compatibility matches was based on combined reciprocal compatibility scores in the need areas of inclusion and control, since it was believed that these would be most influential in an initial therapy interview. There are ten possible compatibility measures which can be computed from the FIRO-B. There are three kinds of compatibility scores (reciprocal, originator, and interchange) and each type of compatibility may be measured for each of the three need areas (inclusion, control, and affection). The tenth compatibility score is global compatibility and is merely the summation of the absolute value of the nine other compatibility scores.

Pearson correlation scores were computed with the ten compatibility scores and the four rates (ApD, ApH, AvD, and AvH). Correlations were run separately for male clients, female clients, male therapists, female therapists, same sex dyads, opposite sex dyads, and overall. Some strong and intriguing trends emerged (see Table 6). Most apparent is that nearly all significant correlations (15 of 17) involve responses to clients expression of hostility, most of these are avoidance responses by the therapist (12 of 15). Invariably as compatibility increases therapists avoid hostility more and approach it less. This is due mainly

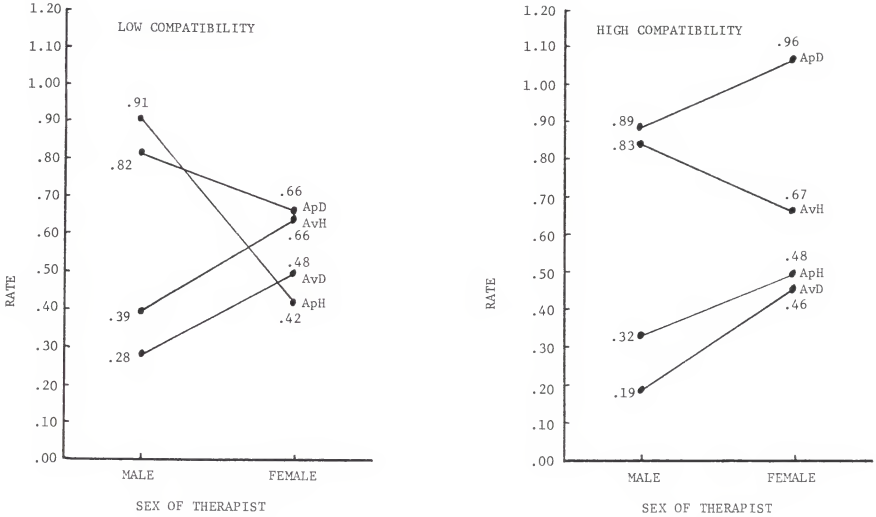


Figure 5. Graphs of all rates by sex of therapists for high and low compatibility dyads.

TABLE 6
SIGNIFICANT CORRELATIONS BETWEEN VARIOUS COMPATIBILITY SCORES AND RATES

SEX	RATE	COMPATIBILITY TYPE	NEED AREA	r	p
MALE CLIENTS (n = 20)	AvD	originator	inclusion	+.45	.04
	AvH	originator	affection	+.50	.02
FEMALE CLIENTS (n = 20)	ApD	originator	affection	+.47	.04
	AvH	reciprocal	control	+.45	.05
	AvH	interchange	control	+.50	.02
MALE THERAPIST (n = 20)	ApH	reciprocal	control	-.60	.005
	ApH	interchange	control	-.62	.004
	AvH	reciprocal	control	+.83	.0001
	AvH	interchange	control	+.77	.0001
	AvH	interchange	affection	+.49	.03
	AvH	global	---	+.69	.0008
SAME SEX DYAD (n = 20)	AvH	reciprocal	control	+.46	.04
	AvH	interchange	control	+.49	.03
OVERALL (n = 40)	ApH	reciprocal	control	-.31	.03
	AvH	reciprocal	control	+.41	.008
	AvH	interchange	control	+.37	.02
	AvH	global	---	+.33	.04

to the effect of male therapists since there were no significant correlations for female therapists. The need area of control was most potent with 11 of the 17 significant correlations. The need area inclusion yielded one significant correlation and affection yielded three. There were six significant correlations with reciprocal compatibility scores, seven with interchange compatibility, and two each for originator and global compatibility scores.

The data were further partitioned to study interactions for each sex therapist with same versus opposite sex clients. Results were very consistent with those reported above with male therapists approaching hostility less and avoiding it more as compatibility increased with both same or opposite sex clients. All significant correlations for male therapists were in the control need area. This partitioning revealed an interesting finding for women therapists not seen before. The need area of affection was important when women counseled women, but not men. Rate of ApD decreased with higher reciprocal compatibility in the affection need area ($r = -.91$; $p = .0002$), and increased with higher originator compatibility for affection ($r = +.70$; $p = .03$). Rate of AvH decreased with increased originator compatibility for affection ($r = -.64$; $p = .04$) and interchange compatibility for affection ($r = -.83$; $p = .003$).

CHAPTER IV
DISCUSSION

Though sex of the client failed to emerge as a significant variable affecting therapists responses to clients' expressions of hostility and dependency, study does yield some intriguing conclusions. It is possible that the analogue-nature of the therapy situation studied here may account for the lack of significant effects due to client sex. Though they were instructed to bring in a real problem to talk about with a therapist, the subjects designated as "clients" in this study must have less of a commitment to the process of interaction called psychotherapy than genuine clients in therapy have. Consequently their impact on the process of psychotherapy, and thus on the behavior of the therapist, is diminished. Another factor contributing to this may be the fact that the therapy sampled was from an initial interview only, presenting very little opportunity for strong process components of therapy, such as transference or counter-transference, to develop.

The situation for therapists in this study is considerably different. First of all, they were all genuine therapists who had no doubt conducted many similar initial interviews in their careers. Furthermore, though they were not informed as to the specific nature of the experiment, they were no doubt aware that their performance was being evaluated in some way, thus their professional self-esteem was involved. So one of the limitations of this kind of first interview, therapy-analogue study may be that the therapists maintain a higher level of commitment to the

process of therapy than the clients do, and thus therapists variables predominate over client variables.

Another design consideration which might be relevant here is the fact that this was a repeated measures design for therapists' behavior. Each therapist appeared in four interviews while the clients each appeared only once. This might have provided greater reliability for therapist measures permitting significant affects to be detected.

Some of the non-significant trends observed were opposite to the hypothesized direction. There was a trend for therapists to approach dependency more with males than with female clients especially in high-compatibility dyads, and also a trend to approach hostility more in females than in males. It was hypothesized that a therapist, who was influenced by cultural sex-role stereotypes would approach dependency more in females and hostility more in males, thus reflecting and reinforcing the stereotypes of women as passive and dependent and the opposites for men. The observed trends may indicate that therapists find expressions of dependency made by male clients to be more significant and worthy of therapeutic attention than similar expressions made by female clients. The same interpretation could explain the increased rate of approach by therapists to hostility expressed by female clients as opposed to males. This may reflect an awareness of sex-role stereotypes on the part of the therapists and their belief that expressed attitudes or behaviors by clients that transgress cultural stereotypes are more likely to be a problem for clients and thus deserve attention in therapy. In this case the therapeutic goal may be the loosening of limits imposed by stereotypes to allow women freer expression of aggressive and hostile behaviors and to allow men to acknowledge and integrate their dependency needs.

Analysis of the variations in the four different rates reveals some dynamics of interest in the initial stages of therapy. Overall it is the handling of hostility that differentiates therapists in the initial therapy session. It appears to be a consistent therapeutic procedure to approach dependency at a high rate in the early stages of therapy. This is to be expected and has been shown in other research to be related to clients remaining versus terminating therapy (Winder et al., 1962). As a group female therapists avoided dependency more than male therapists, possibly indicating that they see dependency as less of a problem worthy of therapeutic intervention.

Therapists were much more varied in their responses to clients' expressions of hostility and the effect here is not a simple one but rather an interaction between therapist sex and compatibility, which is the most significant finding in this study. The compatibility manipulation was effective for male therapists only and especially influenced their rate of approach to hostility. They approached hostility less and avoided it more as compatibility with clients increased. The differences in the mean rates of ApH and AvH with high and low compatibility dyads was very large. Female therapists responded to hostility at a more consistent, intermediate level throughout the compatibility manipulation. With the sole exception of approach to dependency, female theapists were more consistent in their responding throughout the study. One possible interpretation is that, in the sample of therapists used in this study, women were more comfortable and consistent (perhaps less ambivalent) in their handling of hostility than were the men. This may reflect a trend in the mental health profession overall. The field of psychology and especially the practice of psychotherapy stresses many behaviors and

interests that are stereotypically defined as "feminine." These include a focus on interpersonal needs and relationships and on feelings. This view is reflected in a number of research studies (Abramowitz, Abramowitz, & Weitz, 1976; Carter, 1971).

However for a woman to achieve success in a profession she must exhibit many "masculine" traits such as achievement motivation, competitiveness, and assertiveness. Thus the mental health profession may be populated with women who are strong on "masculine" traits and by men who exhibit more "feminine" traits than men in general.

The fact that the female therapists were not influenced as much as males by the compatibility manipulation raises various interpretations. Perhaps the women therapists were more objective than males, perhaps they more closely approximated the model of a Rogerian therapist and responded unconditionally to their clients, or perhaps they were less sensitive than their male counterparts.

Research literature evaluating the effects of sex of the therapist on therapy process and outcome yield varying results. A few studies have found women therapists to be more empathic than male therapists (Abramowitz et al., 1970; Carter, 1971; Hill, 1975). Some studies have found no difference in level of empathy between male and female therapists and that therapist sex is not related to treatment outcome (Olesker & Balter, 1972; Scher, 1975). One result that appears fairly often in the literature which is supposedly congruent with sex-role expectations is that same-sex dyads lead to increased empathy, more discussion of feelings, and more supportive behavior by the therapist (Hill, 1975; Olesker & Balter, 1972). I could find no previous studies which reported that male therapists were more empathic or sensitive than their female counterparts.

Any conclusions about therapists' effects derived from this study must be very limited due to the small number (10) of therapists used. It is also difficult to assess what the different rates of responding between male and female therapists means or what effect this might have on the outcome of therapy. Outcome data based on client and therapist evaluations are available as part of the larger research project (Goldman et al., 1977) that could further educate us in this area. Do clients or therapists report better satisfaction in therapy when client expressed hostility is approached rather than avoided? Is the tendency to avoid or approach hostility with high- and low-compatibility clients reflected in changes in therapists or clients mood scale scores.

The effect of the compatibility manipulation in male therapists does not seem to fit with the typical masculine sex-role. Men are stereotypically believed to be less emotional than women, less sensitive interpersonally, more objective, and task oriented. The results of this study are also inconsistent with previous research which matched dyads in the FIRO-B (Jones, 1976; Mendelsohn & Rankin, 1969). These studies found that females were affected by compatibility but males were not, though the effects in both of these studies were on client behaviors rather than therapist behaviors.

The male therapists' variability in responding to client-expressed hostility is equally incongruent with sex-role stereotypes. Since hostility and aggression are culturally prescribed acceptable behaviors for males, but unacceptable for females, one would expect male therapists to be more adept and less ambivalent in dealing with hostility than female therapists. Again there are no similar findings in the research

literature. Two studies by Gamsky & Farwell (1966, 1967) found that sex of the counselor was not related to their handling of hostility.

Previous research has revealed some conditions which influence therapists responding to hostility. Bandura et al. (1960) found that "therapists who readily expressed hostility in direct forms were less likely to ignore the patients hostility than were therapists who were rated low on the direct hostility scale. In addition therapists high in approval seeking were less likely to make efforts to explore patients' hostility, were more likely to ignore hostility, and were more likely to change the discussion from hostility to unhostility than were therapists who displayed low approval seeking" (p. 3). This suggests a possible follow-up analysis of the present data. Therapists scores on Berger's scale of acceptance of self and acceptance of others (Berger, 1952) were collected as part of the larger research project but were not used in this study. From intuitive reasoning one would expect a strong correlation between low acceptance of self and a high need for approval from others. If this is true, one might hypothesize that the interaction effect for male therapists with compatibility and handling of client-expressed hostility reflects lower scores on acceptance of self and acceptance of others. The corrollary hypothesis would be that the female therapists' more consistent response to hostility reflects their higher scores on acceptance of self and others. Male therapists, because of low acceptance of self scores, have a strong need to be approved of by high-compatible clients. Therefore they would avoid hostility with these clients because they would fear that such a confrontation would jeopardize their gaining approval from the client. The need to be approved of by low compatibility clients is not as great so they can approach hostility in these clients.

The results from the correlational analyses were generally consistent with those of the analysis of variance procedure in that significant correlations between rates and compatibility scores emerged for male therapists but not for female therapists. The results are also consistent in that invariably increases in compatibility of any type lead to increased avoidance of hostility and decreased approach to hostility. The most straightforward interpretation of this result is apparent when we consider the definition of compatibility. According to Schutz, compatibility is "a property of a relation between two or more persons . . . that leads to mutual satisfaction of interpersonal needs and harmonious coexistence" (1958, p. 105). When compatibility is low the prospects for peaceful coexistence are poor so there is essentially nothing to lose by approaching a threatening topic like hostility. Other possible interpretations of this result have already been discussed.

Examination of the correlation results reveals one trend that is congruent with sex-role stereotypes. Four of the five significant correlations for males were in the control need area indicating that, for male therapists, the need to control is a powerful dynamic in therapy, whether they are counseling male or female clients. The fact that 11 of the 15 significant correlations were in the control need area lends more credibility to the impact that matching in this need area has on the therapy process. The lack of significant correlations for opposite sex-dyads is contrary to earlier findings from this research project which found more significant correlations between compatibility scores and outcome measures with opposite sex dyads (Goldman et al., 1977).

When the data were further partitioned to study interactions for each sex of therapist separately with same and opposite sex clients a very interesting result emerged for female therapists. Compatibility in the need area of affection is important when women counsel women but not when they are paired with men. It is also significant that with women therapists counseling women clients, compatibility in the affection need area was negatively correlated with avoidance of hostility. All correlations between compatibility and rate of avoidance to hostility were positive for male therapists. Thus the specific pairing of a woman therapist with a woman client produces effects in therapy that are not found in any other sex-pairing. This finding is in some ways consistent with the results of Hill (1975) who found that women therapists counseling women clients yielded higher levels of empathy than any other sex pairing and may be interpreted as supporting the feminists' contention that women should seek counseling only from women therapists.

CHAPTER V
CONCLUSION

This study was intended to explore the effects of sex-role stereotypes on the process of psychotherapy. The literature review revealed numerous studies documenting the existence of stereotypes among mental-health professionals, but few studies carefully assessing how this would be revealed in and influence the process of therapy. It was felt that, if sex-role stereotypes were operating in therapy, it would be most apparent in the therapists' handling of client-expressed dependency and hostility, behaviors which are central to sex-role stereotypes and which to a large extent discriminate betweem "masculine" and "feminine" gender roles. Numerous hypotheses were offered based on the assumption that therapists' rates of approach and avoidance to client expressed hostility and dependency would vary as a function of client sex. Compatibility between therapist and client was also introduced as an independent variable in this study with the assumption made that compatibility, which previous research has shown, facilitates verbal conditioning, would have a potentiating effect upon the sex-role stereotypes operating in therapy.

The results of the study gave little or no support to the existence of sex-role stereotypes operating to influence the process of therapy. Sex of the client did not influence the variance in the rates of approach and avoidance to hostility and dependency. There was a significant interaction effect of therapist sex by compatibility by rate.

Compatibility influenced responses to client-expressed hostility among male therapists but not among female therapists. This result is seen as being contrary to expectations based on sex-role stereotypes. The results of this study find few parallels in previous research but indicate that sex of the therapist and compatibility in the therapeutic dyad are important variables effecting therapists dealing with hostility and warrant further investigation.

Correlation analyses of ten compatibility scores derived from the FIRO-B and rates of approach and avoidance to hostility and dependency support the effectiveness of compatibility matching in therapy. Results for male therapists were consistent with those reported above with compatibility correlated primarily in the control need area with therapists' responses to hostility. Unique effects were found in pairing female therapists with female clients in that the need area of affection was significant.

A possible refinement for future research would be to assess the interaction of therapist sex and compatibility on responses to hostility and dependency using standardized client roles which incorporate the behaviors in greater intensity than found in this study. The specific analogue nature of this study, with college students used as clients, is believed to dilute the impact of the client stimuli.

APPENDIX A
RULES FOR LOCATING SEGMENTS WITHIN FULL INTERVIEWS

Master tapes are composed of three-minute segments of interviews with interviews and segments within interviews in randomized order. There are a total of 120 segments with 3 segments from each of the 40 approximately 50 minute interviews. Position of segments within each interview was determined by these rules.

Rule 1. Segment 1 begins at the beginning of the interview and continues as described in Rule 4. Specifically, the beginning of the interview is defined as the first video-resolved frame with clear audio. At that point the counter on the play-back recorder is set to 000.

Rule 2. Segment 2 begins with the first statement (as defined in the Method section) which begins after 17 minutes of interview time have elapsed. Specifically, the playback recorder is run forward to 425. It is then played past 430, and the first statement beginning after that point (430) is noted. The playback recorder is then rewound, played forward, and recording started at the identified statement. All machines used in this recording of master tapes were identical SONY units. (Other machines would need to have different counter numbers specified.)

Rule 3. Segment 3 begins with the first statement (as defined in the Method section) which begins after 17 minutes of interview time have elapsed. The same procedure is used as in Rule 2, with counter settings 595 and 600. If interview ends prior to 3 minutes elpased time, rewind

100 counter units and use that number as the starting point. If the interview was too long, use 650 or 700 as the starting point.

Rule 4. On all segments, stop recording at the first sentence or clause end after 180 seconds or at 185 seconds.

APPENDIX B
SCORING MANUAL

A. Scoring Unit and Interaction Sequence

1. Definition. A unit is the total verbalization of one speaker bounded by the preceding and succeeding speeches of the other speaker with the exception of interruptions.

There are two types of scoring units: The "patient statement" (P St) and the "therapist response" (T R). A sequence of these two units composes an "interaction sequence."

Example:

P. I can't understand how you can stand me. (P St)

T. You seem to be very aware of my feelings. (T R)

2. Pauses are not scored as separate units. The verbalization before and after the pause is considered one unit. Therapist silences are scored as prescribed under Part C2e of this manual. There are no patient silences in this system.

3. Interruptions. Statements of either therapist or patient which interrupt the other speaker will be scored only if the content and temporal continuity of the other speaker is altered by the interruption. Then, the interrupting verbalization becomes another unit and is scored. A non-scored interruption is never taken into account in the continuation of the other speaker.

Interruption scored as one unit:

P. I asked him to help me and ---

T. Why was that?

P. --- he refused to even try.

Non-interruption scored as 3 units:

P. I asked him to help me and ---

T. Why was that?

P. I don't know.

Verbalizations such as "Um hmm" or "I see" are ignored in scoring unless they are so strongly stated as to convey more than a listening or receptive attitude.

Patients' requests for the therapist to repeat his response are considered interruptions and are not scored. However, therapists' requests of this sort are scored as units (as approach or avoidance of the patient statement).

B. Categories of Patient Statements and Patient Responses

There are three categories: Dependency, Hostility, and Other. They are scored as exhaustive categories. All discriminations are made on the basis of what is explicitly verbalized by the speaker in the unit under consideration. One statement may be scored for several categories.

1. Hostility category. The subcategories of hostility listed below are not differentiated in the scoring but are listed here to aid in identification of hostility.

   a. Hostility. Hostility statements include description or expression of unfavorable, critical, sarcastic, depreciatory remarks; oppositional attitudes; antagonism, argument, expression of dislike, disagreement, resentment, resistance, irritation, annoyance, anger; expression of aggression and punitive behavior, and aggressive domination.

1. Anger:

   P. I'm just plain mad!

   P. I just could't think -- I was so angry.

   P. My uncle was furious at my aunt.

2. Dislike: Expresses dislike or describes actions which would usually indicate dislike.

   P. I just don't get interested in them and would rather be somewhere else.

   P. I've never ever felt I liked them and I don't suspect I will.

   P. He hates editorials.

3. Resentment: Expresses or describes a persistent negative attitude which does or might change to anger on a specific occasion.

   P. They are so smug; I go cold whenever I think about having to listen to their "our dog" and "our son." Boy!

   P. They don't ever do a thing for me so why should I ask them over?

   P. Dad resents her questions.

4. Antagonism: Expresses or describes antipathy or emnity.

   P. It's really nothing definite, but we always seem at odds somehow.

   P. There is always this feeling of being enemies.

5. Opposition: Expresses or describes oppositional feelings or behavior.

   P. If he wants to do one thing, I want to do another.

P. It always seems she is against things. She is even against things she wants.

P. No, I don't feel that way (in response to T's assertion).

6. Critical attitudes: Expresses negative evaluations or describes actions which usually imply negative evaluations. Critical attitudes towards oneself are not scored as hostility. In general hostility must be projected outwards.

P. If I don't think the actors are doing very well, I just get up and walk out.

P. There is something to be critical about in almost everything anyone says or does.

7. Aggressive actions: Acts so as to hurt another person or persons, either physically or psychologically.

P. He deserves to suffer and I'm making it that way every way I can.

P. I can remember Mother saying: "We slap those little hands to make it hurt."

b. Hostility anxiety. A statement including expression of fear, anxiety, guilt about hostility, or reflecting difficulty expressing hostility.

P. I just felt so sad about our argument.

P. I was afraid to hit her.

P. After I hit her I felt lousy.

c. Hostility acknowledgment or agreement. A statement agreeing with acknowledging the therapist's approach toward hostility

is scored as further hostility. May give example. May convey some conviction or may simply agree with therapist's response.

T. You were angry.

P. Yes!

2. Dependency categories.

a. Definition. Any explicit expression or description of help-seeking, approval-seeking, company-seeking, information-seeking, agreement with others, concern about disapproval, or request that another initiate discussion or activity.

b. Scoreable categories: The subcategories listed below are scored exhaustively.

1. Problem Description: States problem in coming to therapy, gives reason for seeking help, expresses a dependent status, or a general concern about dependency. Because of the design of this study, the pateints' initial statement of the problem or reason for coming to therapy will not be scored as dependency. Patients were explicitly instructed to bring a problem to talk about creating an artificial expression of dependency. Subsequent spontaneous statements of problems will be scored as dependency.

P. I wanted to be more sure of myself. That's why I came.

P. I wanted to talk over with you my reasons for dropping out of school next quarter.

P. Part of the reason I'm here is that everything's all fouled up at home.

P. I depend on her, am tied to her.

P. I want to be babied and comforted.

2. Help-Seeking: Asks for help, reports asking for help, describes helpseeking behavior.

P. I asked him to help me out in this situation.

P. What can you do for him?

P. I try to do it when he can see it's too hard for me.

3. Approval-Seeking: Requests approval or acceptance, asks if something has the approval of another, reports having done so with others, tries to please another, asks for support or security. Includes talk about prestige. Expresses or describes some activity geared to meet his need.

P. I hope you will tell me if that is what you want.

P. If there was any homework, I did it so Dad would know I was studying like a good girl.

P. Is it alright if I talk about my girl's problem?

P. That's the way I see it, is that wrong?

P. I asked him if I were doing the right thing.

4. Company-Seeking: Describes or expresses a wish to be with people, describes making arrangements to do so, describes efforts to be with others, talks about being with others.

P. It looks as if it'll be another lonely weekend.

P. Instead of studying, I go talk with the guys.

P. I only joined so I could be in a group.

P. We try to see if other kids we know are there, before we go in.

5. Information-Seeking: Asks for cognitive, factual or evaluative information, expresses a desire for information from others, arranges to be the recipient of information.

   P. I asked him why he thought a girl might do something like that.

   P. I came over here to see about tests you have to offer. I want to know what they say.

   P. I'm planning to change my major. I'd like to know how to do it.

6. Agreement with another: Responds with ready agreement with others, readily accepts the therapist's reflection. Often illustrates therapist's remarks with examples, draws a parallel example to indicate agreement. May accept preceding statement on authority or if preceding statement was a therapist approach to dependency, may simply agree with it. Affirmative responses to therapist's non-interpretive questions which demand a "yes" or "no" are not scored as dependency.

   P. Oh, yes! You're absolutely right about that.

   P. Immediately I felt he was right and I had never thought about it that way.

   T. Then you wanted to get some help?

   P. Yes.

7. Concern about disapproval: Expresses fear, concern, or unusual sensitivity about disapproval of others, describes unusual distress about an instance of disapproval,

insecurity, or lack of support. Little or no action is taken to do something about the concern.

P. She didn't ever say a thing but I kept on wondering what she doesn't like about me.

P. My parents will be so upset about my grades, I don't even want to go home.

P. It seems like I always expect I won't be liked.

P. I can't understand how you can stand me when I smoke.

P. I'm sorry I got angry at you.

8. Initiative-Seeking: Asks the therapist or others to initiate action, take the responsibility for starting something (to start discussion, determine the topic). Arranges to be a recipient of T's initiative. May solicit suggestions.

P. Why don't you say what we should talk about now?

P. If you think I should keep on a more definite track, you should tell me.

P. I got my advisor to pick my courses for next time.

P. Tell him what to do in these circumstances.

C. Categories of Therapist Responses.

Therapist responses to each scored patient statement are divided first into two mutually exclusive classes, approach and avoidance responses. When both approach and avoidance are present, score only the portion which is designed to elicit a response from the patient.

1. Approach responses. The following subcategories are exhaustive. An approach response is any verbalization by the therapist which seems designed to elicit from the patient further expression or

elaboration of the dependent of hostile (or other) feelings, attitudes, or actions described or expressed in the patient's immediately preceding statement, i.e., the part of the preceding statement which determined its placement under dependency, hostility, or other. Approach is to the major category, not specific subcategories.

a. Approval: Expresses approval of or agreement with the patient's feelings, attitudes, or behavior. Includes especially strong "Mm-hmm!," "Yes."

P. May I just be quiet for a moment?

T. Certainly.

P. I have my girlfriend's problems on my mind. Could we talk about them?

T. Why don't we talk about that?

b. Exploration (probing): Includes remarks or questions that encourage the patient to describe or express his feelings, attitudes, or actions further, asks for further clarification, elaboration, descriptive information, calls for details or examples. Should demand more than a yes or no answer; if not, may be a "label."

P. How do I feel? I feel idiotic.

T. What do you mean, you feel idiotic?

P. I can't understand his behavior.

T. What is it about his behavior you can't understand?

c. Reflection: Repeats or restates a portion of the patient's verbalization of feeling, attitude, or action. May use phrases of synonymous meaning. Therapist may sometimes agree

with his own previous response; if the client had agreed or accepted the first therapist statement, the second therapist statement is scored as a reflection of the client statement.

P. I wanted to spend the entire day with him.

T. You wanted to be together.

P. His doing that stupid doodling upsets me.

T. It really gets under your skin.

d. Labeling: The therapist gives a name to the feeling, attitude, or action contained in the patient's verbalization. May be a tentative and broad statement not clearly aimed at exploration. Includes "bare" interpretation, i.e., those not explained to the patient. May be a question easily answered by yes or no.

P. I just don't want to talk about that any more.

T. What I said annoyed you.

P. She told me never to come back and I really did have a reaction.

T. You had some strong feelings about that -- maybe disappointment or anger.

e. Interpretation: Points out and explains patterns or relationships in the patient's feelings, attitudes, and behavior: Explains the antecedents of them, shows the similarities in the patient's feelings and reactions in diverse situations or at separate times.

P. I had to know if Barb thought what I said was right.

T. This is what you said earlier about your mother. . . .

f. Generalization: Points out that patient's feelings are natural or common.

P. I want to know how I did on those tests.

T. Most students are anxious to know as soon as possible.

P. Won't you give me the scores?

T. Many students are upset when we can't.

g. Support: Expresses sympathy, reassurance, or understanding of patient's feelings.

P. It's hard for me to just start talking.

T. I think I know what you mean.

P. I hate to ask favors from people.

T. I can understand that would be difficult for you.

h. Factual Information: Gives information to direct or implied questions. Includes general remarks about the counseling procedure.

P. Shall I take tests?

T. I feel in this instance tests are not needed.

P. What's counseling all about?

T. It's a chance for a person to say just what's on his mind.

2. Avoidance responses. The following subcategories are exhaustive. An avoidance response is any verbalization by the therapist which seems designed to inhibit, discourage, or divert further expression of the dependent, hostile, or other patient categories. The therapist attempts to inhibit the feelings, attitudes, or behavior described or expressed in the immediately preceding patient statement, i.e., the part of the preceding statement which determined its placement under dependency, hostility, or

other. Avoidance is avoidance of the major category, not specific subcategories.

a. Disapproval: Therapist is critical, sarcastic, or antagonistic toward the patient or his statements, feelings, or attitudes, expressing rejection in some way. May point out contradictions or challenge statements.

P. Why don't you make statements? Make a statement. Don't ask another question.

T. It seems that you came here for a reason.

P. Well, I wonder what I do now?

T. What do you think are the possibilities? You seem to have raised a number of logical possibilities in our discussion.

P. I'm mad at him: That's how I feel.

T. You aren't thinking of how she may feel.

b. Topic Transition: Therapist changes or introduces a new topic of discussion not in the immediately preceding patient verbalization. Usually fails to acknowledge even a minor portion of the statement.

P. Those kids were asking too much. It would have taken too much of my time.

T. We seem to have gotten away from what we were talking about earlier.

P. My mother never seemed interested in me.

T. And what does your father do for a living?

c. Ignoring: Therapist responds only to a minor part of the patient response or responds to content, ignoring affect.

May under- or over-estimate affect. May approach the general topic but blatently ignore the affect verbalized.

P. You've been through this with other people so help me out, will you.

T. You are a little uneasy.

P. You can see I don't know what to do and I want you to give me advice.

T. Just say whatever you feel is important about that.

P. My older sister gets me so mad I could scream.

T. Mm-hmm. How old did you say she was?

d. Mislabeling: Therapist names attitudes, feelings, or actions which are not present in the actual verbalization preceding the response.

P. I just felt crushed when she said that.

T. Really burned you up, huh?

P. I don't know how I felt -- confused, lost --

T. I wonder if what you felt was resentment.

3. Dependency and hostility initiated by therapist: Scored as approach whenever the therapist introduces the topic of dependency or hostility, i.e., when the patient statement was not scored as the category which the therapist attempts to introduce.

P. Last week I talked about Jane.

T. You've mentioned a number of things you have done to please her.

P. (Enters office)

T. Now, how may I help you?

P. I was late for class this morning.

T. I wonder if you dislike the teacher or the class?

P. I like to run around in blue jeans.

T. You hate your mother.

Summary Sheet for Scoring

I. PATIENT RESPONSES

A. Hostility

1. Anger
2. Dislike
3. Resentment
4. Antagonism
5. Opposition
6. Critical attitudes
7. Aggressive actions
8. Hostility anxiety
9. Hostility acknowledgment or agreement

B. Dependency

1. Problem description
2. Help-seeking
3. Approval-seeking
4. Company-seeking
5. Information-seeking
6. Agreement with another
7. Concern about disapproval
8. Initiative-seeking

II. THERAPIST RESPONSES

A. Approach

1. Approval
2. Exploration (probing)
3. Reflection
4. Labeling
5. Interpretation
6. Generalization
7. Support
8. Factual information

B. Avoidance

1. Disapproval
2. Topic transition
3. Ignoring
4. Mislabeling

C. Dependency and Hostility Initiated by the Therapist

are scored as approach.

APPENDIX C

DESCRIPTIVE STATISTICS FOR RATES OF APPROACH AND AVOIDANCE OF HOSTILITY AND DEPENDENCY

DYAD MATCH	RATE	N	MEAN	STANDARD DEVIATION
Male therapist,	ApD	5	0.89	0.13
male client,	ApH	5	1.09	1.13
low-compatibility	AvD	5	0.32	0.26
	AvH	5	0.45	0.32
Male therapist,	ApD	5	1.02	0.17
male client,	ApH	5	0.23	0.23
high-compatibility	AvD	5	0.07	0.10
	AvH	5	0.83	0.20
Male therapist,	ApD	5	0.75	0.17
female client,	ApH	5	0.72	0.08
low-compatibility	AvD	5	0.25	0.17
	AvH	5	0.33	0.13
Male therapist,	ApD	5	0.76	0.18
female client,	ApH	5	0.42	0.36
high-compatibility	AvD	5	0.32	0.19
	AvH	5	0.84	0.17
Female therapist,	ApD	5	0.61	0.41
male client,	ApH	5	0.31	0.21
low-compatibility	AvD	5	0.50	0.28
	AvH	5	0.69	0.21
Female therapist,	ApD	5	1.22	0.69
male client,	ApH	5	0.36	0.50
high-compatibility	AvD	5	0.40	0.34
	AvH	5	0.64	0.50
Female therapist,	ApD	5	0.72	0.18
female client,	ApH	5	0.53	0.34
low-compatibility	AvD	5	0.47	0.18
	AvH	5	0.63	0.34
Female therapist,	ApD	5	0.70	0.19
female client,	ApH	5	0.60	0.56
high-compatibility	AvD	5	0.53	0.16
	AvH	5	0.71	0.41

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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